Access to Records Request
Wyoming Department of Health

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), clients have a right to request the opportunity to inspect and copy their health information. This right to access does not pertain to information compiled in anticipation of or use in a civil, criminal or administrative action, to information received in confidence from an individual other than the health care provider, psychotherapy notes or if there is a belief that access to the information could be harmful to the client or others. We will evaluate each request and make a determination. A fee may be charged if a client has received access to the same information within the previous 12 months.

For Office Use Only:
☐ Approved ☐ Denied
☐ Delayed, we will act on this request by _____
Comments: _____

WDH Representative Signature: _____
Documentation of Relationship:
☐ Reviewed ☐ Attached

I hereby request access to health information for:

Name:	ID Number:
Address:	Date of Birth:
Record Holder:	Date of Request:

Scope of Access Requested

I would like access to: ☐ All the records ***or***
☐ The portion of the records concerning:
(Specify type of disease, accident, dates of treatment or other portion of records of interest.)

_____

_____

Type of Access Requested

- ☐ **Inspection**. Please let me know when and where I may inspect my records and the fee, if any. I understand that an employee of Wyoming Department of Health may be present and I may not mark or alter the record in any way.
- ☐ **Copies**. I would like copies of the records requested.
- ☐ I would like the information in the following format: _____

Charges

Inspection: I understand I may be charged a reasonable fee for clerical costs incurred in making records available for inspection.
Copies of Transfer: I understand a reasonable fee may be charged for copies.
☐ I hereby agree to pay all charges specified above. ☐ Please contact me with the total cost I will incur.

Signed: _____ **Print Name:** _____ **Telephone:** _____ **Date:** _____

If not signed by the patient, please indicate the relationship:
☐ Guardian or conservator of an incompetent client
☐ Parent or guardian of minor client
☐ Beneficiary or personal representative of deceased client
☐ Other (specify)
Name of Client: _____